Attachment V

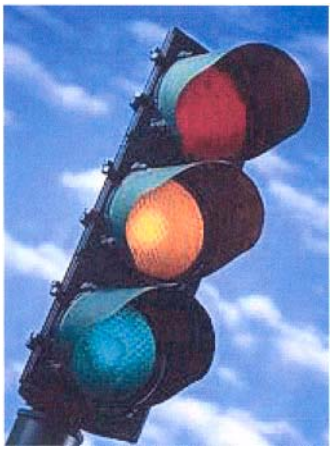
IS News Bulletin #010
10/3/2005

Integrated System News Bulletin

Submitting Medi-Cal Claims with Service Dates After 9/30/04 with Late Code 10

Attention: Fee-For-Service Network Providers

STOP - Impact to You



The DMH Chief Information Office, Revenue Management, Medi-Cal Professional Services and Authorizations Division and Financial Services have received many inquiries on the proper handling of claims aged over six months beyond the date of service that require a late code for submission to the State for Medi-Cal reimbursement. Some of these claims were entered timely by the provider, but, for a variety of reasons, were held in submitted or pending status. Claims that were stuck in these categories have now been processed in the IS and some are showing on reports as local denials by the IS due to Deny Source: Rules or CICS.

CAUTION – What You Need to Know

The Department has requested that the State reconsider its position on prorated payments for claims over 6 months old. Currently, the State does not prorate claims for SD/MC services. State Medi-Cal prorates payments for physical medical services claims at 75 percent for claims between 6 and 9 months from the date of service and at 50 percent for claims between 9 and 12 months from the date of service. There is no reimbursement for services greater than twelve months.

DMH and County Counsel are pressing the State to treat mental health claims the same as they treat physical health claims. There is no certainty that this will occur, but initial response has been encouraging.

Providers should submit claims that have aged over 6 months from the date of service so that they are "time stamped" and don't age further. If an agreement is reached with the State on prorated payments, then these claims will become eligible. Even claims older than 12 months from the date of service should be submitted; especially if the provider organization believes the claim was not submitted timely due to IS problems/ errors. The State will deny such claims,

but the denial will establish the claim as eligible for an appeal through the DMH Dispute Resolution Process.

GO - What You Need to Do

For the claims described above, it will be necessary to submit them with late code 10 to get them through the IS and MIS/RGMS edits. For claims that fall outside the period from February 2004 through September 2004 that was agreed to by the State for use of the late code 10, Sierra will remove the late code 10 prior to submission and the claim will be submitted to Medi-Cal without a late code. This process ensures the claim is date stamped with the State submit date in the event the Department is successful in its efforts to gain approval of prorated payment for claims beyond 6 months from the date of service. In cases where the claim is greater than twelve months, the State's denial can be used for appeal.

If a valid late code accurately describes why a claim is late, please use the appropriate code rather than the late code 10. Late code 10 should ***only*** be used for claims submitted late to Medi-Cal because of Integrated System problems or errors.

Please note that each individual claim must be evaluated by the provider organization to determine the appropriate late code to use. Late code descriptions are available in the Integrated System Codes Manual. The IS Codes Manual can be found on the IS Website at http://dmh.lacounty.info/hipaa/index.html. If you have questions regarding entering claims in the IS, help with error messages, claiming regulations, requirements or the Dispute Resolution Process, please call the Provider Relations Unit at (213) 738-3311.